EASTERN VIRGINIA GRADUATE SCHOOL OF MEDICINE
AFFILIATED HOSPITALS

Department of Director, Residency Program

Department of
PATHOLOGY

Department of Pathology
EVMS-EVGSM
P.O. Box 1980
Norfolk, Va. 23501-1980

APPLICATION FOR RESIDENT POSITION

Picture

YEAR OF GRADUATE EDUCATION BEING APPLIED FOR:

Y FIRST GRADUATE
Y SECOND GRADUATE YEAR
Y THIRD GRADUATE YEAR
Y FOURTH GRADUATE YEAR
Y FIFTH GRADUATE YEAR
Y SIXTH GRADUATE YEAR
Y SEVENTH GRADUATE YEAR
Y EXTERNSHIP
Y OTHER (SPECIFY) _____

DESIRED STARTING DATE_____

PERSONAL HISTORY: DATE: _____19_____

Name _____US CITIZEN? _____ Social Security No. _____

Present (Mailing) Address _____ Phone_____

Permanent Address _____

Birthplace _____ Marital Status _____

Age _____ Birth Date _____ Children _____

Physical Condition _____ Date of Last Physical Examination _____

Basic Science Certificate? _____ State _____ Year _____
(Yes or No)

Diplomate Yes Y No Y

Licensed to Practice? _____ What State? _____ Year _____
(State Board) (Yes or No)

Available for Interview _____ Dates _____
(Yes or No)

REFERENCES (give names below: Applicant should personally request the Medical School Dean and 3 others to submit letters)

Pre-Medical School Dean _____

Medical School Dean (Letter to include Class Rank) _____

Character Reference _____

Character Reference _____

Character Reference _____

PREMEDICAL TRAINING:

College _____ Years _____ Degree _____
(Name of School)

Post Graduate _____ Years _____ Degree _____
(Name of School)

Business Experience _____ Years _____ Degree _____
(Name of Employee)

Vocational Experience _____ Years _____ Degree _____

MEDICAL TRAINING:

Medical School _____ 19_____ to 19_____ Degree _____ Length of Program _____

Hospital Externships _____ From _____ To _____
(Name of School)

Hospital Internships _____ Type _____ From _____ To _____
(Name of Hospital)

Hospital Internships _____ Type _____ From _____ To _____
(Name of Hospital)

Hospital Residencies _____ Specialty _____ From _____ To _____
(Name of Hospital)

Hospital Residencies _____ Specialty _____ From _____ To _____
(Name of Hospital)

Research Work _____ Type of Work _____ From _____ To _____

Military Status _____

Extra-Curricular Activities _____

_____

_____

_____

FOREIGN GRADUATES:

ECFG Certificate _____
(Year and Number)

Type: _____
(Permanent) Interim)

Type of Visa: _____

NOTE:

A photocopy of Interim or Pe4manent ECFMG certificate is required prior to final appointment as a resident. This should be submitted either with or as soon as possible following submission of this application.

+ Application will not be considered complete until Medical School Transcripts and Letters of Recommendation have been received by this department.

+ Appointments are made for one year by contract which lists stipends and fringe benefits.

+ If appointment is received and accepted by me, I agree to discharge my duties and to complete the term of appointment as offered.

Signature _____ Date _____